**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-864-4352 or visit us at www.ibxtpa.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary/** or call 1-844-864-4352 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | All Professional Providers: **$250** person / **$750** family. Hospitalization: **No deductible**. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and hospitalization | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | All Professional Providers: **$400** person / **$800** family. Hospitalization: N/A. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, health care this plan doesn't cover, and preauthorization penalties. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See **www.ibxtpa.com or call: 1-844-864-4352** for a list of **Preferred providers**. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 20% coinsurance | 20% coinsurance | Deductible applies. |
| | Specialist visit | 20% coinsurance | 20% coinsurance | Deductible applies. |
| | Preventive care/screening/ immunization | No Charge<br>Deductible waived | No Charge<br>Deductible waived | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Limitations may apply. Immunizations are covered at 100%. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance<br>No charge in a hospital setting. | Not Covered | Deductible applies. Physician Outpatient: First $500 covered at 100%, then 20% coinsurance after deductible. Facility Outpatient: Preferred providers - no charge; and Non-Preferred providers - Medicare allowable amount or usual & customary amount. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance<br>No charge in a hospital setting. | Not Covered | Deductible applies. Physician Outpatient: First $500 covered at 100%, then 20% coinsurance after deductible. Facility Outpatient: Preferred providers - no charge; and Non-Preferred providers - Medicare allowable amount or usual & customary amount. Precertification is required. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.ibxtpa.com | Generic drugs | $5 copay | $5 copay | ---None--- |
| | Preferred brand drugs | $5 copay | $5 copay | ---None--- |
| | Non-preferred drugs | $5 copay | $5 copay | ---None--- |
| | Specialty drugs | $5 copay | $5 copay | ---None--- |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge | No Charge | Preferred Facility - no charge. Non-Preferred Facility - Medicare allowable amount or usual & customary amount. Precertification is required. |
| | Physician/surgeon fees | No Charge | No Charge | Precertification is required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | No Charge | No Charge | Must occur within 72 hours of accident. Non-emergency is covered at 20% coinsurance after deductible. Facility charges: Preferred Facility - no charge. Non-Preferred Facility - Medicare allowable amount or usual & customary amount. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Deductible applies. |
| | Urgent care | 20% coinsurance | Not Covered | Deductible applies. Must occur within 72 hours of accident. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | No Charge | Limited to 365 days. Precertification is required. |
| | Physician/surgeon fees | No Charge | No Charge | Precertification is required. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 20% coinsurance | Deductible applies. Substance use disorder: Facility: Preferred Facility - no charge. Non-Preferred Facility - Medicare allowable amount or usual & customary amount. Outpatient Facility: Limited to 30 visits per calendar year and 120 visits per lifetime. |
| | Inpatient services | No Charge | No Charge | Mental/Behavioral health: Facility: No charge up to 365 days. Preferred Facility - no charge. Non-Preferred Facility - Medicare allowable amount or usual & customary amount. Substance use disorder: Limited to 30 days per calendar year; lifetime maximum of 90 days. Detox limited to 7 days per admission; lifetime max of 4 admissions. Preferred Facility - no charge. Non-Preferred Facility - Medicare allowable amount or usual & customary amount. Precertification is required. |
| **If you are pregnant** | Office visits | 20% coinsurance | 20% coinsurance | Deductible applies. |
| | Childbirth/delivery professional services | No Charge | No Charge | Precertification is required. |
| | Childbirth/delivery facility services | No Charge | No Charge | Precertification is required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | Not Covered | Deductible applies. Precertification is required. |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance | Preferred: covered at 20% after deductible, or in an outpatient facility limited to 60 consecutive days during each calendar year. Covered as an inpatient for 60 days after inpatient stay. |
| | Habilitation services | 20% coinsurance | 20% coinsurance | Preferred: covered at 20% after deductible or in an outpatient facility and limited to 60 consecutive days during each calendar year. |
| | Skilled nursing care | No Charge | No Charge | Each day counts as 1/2 day against your available inpatient days. Facility charges: Preferred Facility - no charge. Non-Preferred Facility - Medicare allowable amount or usual & customary amount. Precertification is required. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Deductible applies. |
| | Hospice services | No Charge | Not Covered | Limited to 7 days every 6 months. Precertification is required. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | ---None--- |
| | Children's glasses | Not Covered | Not Covered | ---None--- |
| | Children's dental check-up | Not Covered | Not Covered | ---None--- |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S. (See www.bcbsglobalcore.com)
- Routine eye care (Adult)
- Routine foot care
- Weight loss program

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic care
- Infertility Treatment (Diagnosis and surgical correction only)
- Private-duty nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-844-864-4352 or www.ibxtpa.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage? Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services**
Independence Administrators complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independence Administrators does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
Independence Administrators:

- Provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- Provides free language services to people whose primary language is not English and information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Independence Administrators has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator.

There are four ways to file a grievance directly with Independence Administrators:

- by mail: Independence Administrators,
  ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 844-864-4352 (TTY 711);
- by fax: 215-761-0920; or
- by email: IACivilRightsCoordinator@ibxtpa.com.

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

## Language Access Services:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-864-4352 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-864-4352 (TTY: 711).

注意：如果您使用简体中文，您可以免费获得语言协助服务。请致电1-844-864-4352。

LƯU Ý: Nếu quý vị nói tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-844-864-4352.

ВНИМАНИЕ: Если вы говорите по-русски, вам предлагаются бесплатные услуги переводчика. Позвоните по телефону 1-844-864-4352.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-864-4352.

알림: 한국어 통역서비스가 필요한 분은 1-844-864-4352로 전화하십시오.
통역서비스를 무료로 받으실 수 있습니다.

ATTENZIONE: se parla italiano, sono disponibili per lei servizi di assistenza linguistica gratuiti. Contatti il numero 1-844-864-4352.

انتباه: إذا كنت تتحدث العربية فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على الرقم: 1-844-864-4352.

ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le 1-844-864-4352.

HINWEIS: Wenn Sie Deutsch sprechen, steht Ihnen über Language Assistance Services ein Dolmetscher kostenlos zur Verfügung. Wählen Sie 1-844-864-4352.

ધ્યાન આપો : જો તમે ગુજરાતી બોલી શકતા હો, તો તમારા માટે ભાષા સહાય સેવાઓ, વિના મૂલ્યે, ઉપલબ્ધ છે. 1-844-864-4352 પર કૉલ કરો.

UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-864-4352.

ATANSYON: Si ou pale kreyòl ayisyen, gen asistans ak lang disponib pou ou gratis. Rele 1-844-864-4352.

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសា មន-ខ្មែរ ប្រទេសខ្មែរ សេវាជំនួយភាសាដែលឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ 1-844-864-4352។

ATENÇÃO: se você fala português, serviços de assistência a idioma estão disponíveis gratuitamente para você. Ligue para 1-844-864-4352.

BAA !KON&N&ZIN: Din4 bizaad bee y1n7[ti'go, ata' hane' bee 1k1 i'iilyeed t'11 j77k'e bee n1 ah00t'i'. Koj8' hod77lnih 1-844-864-4352.

PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbisyo ng tulong para sa wika nang walang bayad. Tumawag sa 1-844-864-4352.

注意：日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。1-844-864-4352にお電話ください。

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان، به رایگان در اختیار شما می باشد. با شماره 1-844-864-4352تماس بگیرید.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist coinsurance | 20% |
| Hospital (facility) no cost sharing | $0 |
| Other no cost sharing | $0 |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| | |
|---|---|
| **Total Example Cost** | **$12,800** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $140 |
| Copayments | $0 |
| Coinsurance | $260 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$460** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well_controlled condition)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist coinsurance | 20% |
| Hospital (facility) no cost sharing | $0 |
| Other no cost sharing | $0 |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| | |
|---|---|
| **Total Example Cost** | **$7,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $30 |
| Coinsurance | $130 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$470** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist coinsurance | 20% |
| Hospital (facility) no cost sharing | $0 |
| Other no cost sharing | $0 |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| | |
|---|---|
| **Total Example Cost** | **$1,900** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $0 |
| Coinsurance | $150 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$400** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.